MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3571 03564

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural
d. STREET ADDRESS 05X-2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle Martin Last Adams

4. DATE OF DEATH March 28 1961

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 5, 1874
9. AGE (In years last birthday) 86 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer
10b. KIND OF BUSINESS OR INDUSTRY Canning Factory
11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Adams
14. MOTHER'S MAIDEN NAME Henrietta (maiden name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address John W. Adams, Baltimore, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Rt. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH 18 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 10 19 61 to March 28 19 61, that (I) (we) last saw the deceased alive on March 28 1961, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE Thurston Harrison M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED March 31, 1961
22c. PHYSICIAN'S NAME (Type) Thurston Harrison M.D.
22d. ADDRESS Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF April 1, 1961
23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery
23d. LOCATION (City, town, or county) (State) Near Preston, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton + Son
ADDRESS Federalsburg
25a. REC'D BY REGISTRAR DATE APR 3 '61
25b. REGISTRAR'S SIGNATURE William S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3572

CERTIFICATE OF DEATH

03565

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: talbot

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 30 min.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton 22

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: EASTON Memorial Hosp.
d. STREET ADDRESS: 109 Locust
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

080

3. NAME OF DECEASED (Type or print): First: Arthur Middle: Oliver Last: Bailey
4. DATE OF DEATH: Month: March Day: 16 Year: 19 61

5. SEX: MALE ~~Male~~
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 12-14-1893
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed
10b. KIND OF BUSINESS OR INDUSTRY: Shoe shop
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

(I)

13. FATHER'S NAME: Richard Bailey
14. MOTHER'S MAIDEN NAME: Isabell Leober

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-03-7440
17. INFORMANT — Address: Mrs Pauline Posey, Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Coronary arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to ____ 19__, that (I) (we) last saw the deceased alive on March 16 19 61, and that death occurred at 8 AM, from the causes and on the date stated above.

22a. SIGNATURE: E. C. H. Schmidt M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 16 61
22c. PHYSICIAN'S NAME (Type): E. C. H. Schmidt
22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/15/61
23c. NAME OF CEMETERY OR CREMATORY: Richards Cem
23d. LOCATION (City, town, or county) (State): Easton Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Bradley Easton Md
25a. REC'D BY REGISTRAR — DATE: MAR 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3573

CERTIFICATE OF DEATH

03566

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 13da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton RI, B151
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: Briddle — Last: Blake

4. DATE OF DEATH: Month: 3 — Day: 10 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/10/95

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Briddle

14. MOTHER'S MAIDEN NAME: Un Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: alice Blake — Address: Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Left Lung — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to ____ 19__, that (I) (we) last saw the deceased alive on March 10 1961 and that death occurred at 3:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: March 11 1961

22c. PHYSICIAN'S NAME (Type): F. C. H. Schmidt

22d. ADDRESS: Easton Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-14-61

23c. NAME OF CEMETERY OR CREMATORY: Copperville, Farm

23d. LOCATION (City, town, or county) (State): Easton RI Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James B. Cashell, Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAR 13 '61

25b. REGISTRAR'S SIGNATURE: Clifford L. Horne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3574 03567

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural
d. STREET ADDRESS Hurlock Road 05x2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First John Middle Miller Last Cell
4. DATE OF DEATH Month 3 Day 27 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 24, 1890
9. AGE (In years last birthday) 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer
10b. KIND OF BUSINESS OR INDUSTRY Printing
11. BIRTHPLACE (State or foreign country) Chambersburg, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John F. Cell
14. MOTHER'S MAIDEN NAME Elizabeth M. (maiden name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ———
17. INFORMANT Address Mrs. J. Miller Cell, Federalsburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Vascular Accident	2 days.
DUE TO (b)	Cholecystectomy	4 days.
DUE TO (c)	Cardiac arrythmia	10 yrs.?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 433.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 1960 to March 27, 1961, that (I) (we) last saw the deceased alive on March 26 1961 and that death occurred at 1:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 3-27-61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF March 30, 1961
23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery
23d. LOCATION (City, town, or county) (State) Federalsburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton & Son
ADDRESS Federalsburg, Maryland
25a. REC'D BY REGISTRAR DATE APR 3 '61
25b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3575

CERTIFICATE OF DEATH

03568

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 2 wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Julia — Middle: Ann — Last: Chipponeri

4. DATE OF DEATH: Month: March — Day: 12 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 24 1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Jersey City, N.J.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Fowler
14. MOTHER'S MAIDEN NAME: Annie White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joseph Chipponeri — Address: St. Michaels, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive Heart Failure	1 hrs.
DUE TO (b)	Hypertensive Cardiovascular Dis	10 years.
DUE TO (c)	Generalized Arteriosclerosis	10 years.

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteoarthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1 Jan 1961 to 12 March 1961, that (I) (~~we~~) last saw the deceased alive on 11 March 1961, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: R. Paul Wolfe M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-15-61
23c. NAME OF CEMETERY OR CREMATORY: Elora Leaf Park
23d. LOCATION (City, town, or county) (State): Woodbridge, N.J.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Hamilton Harman
ADDRESS: St. Michaels Md

25a. REC'D BY REGISTRAR DATE: MAR 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3576 03563

1 PLACE OF DEATH
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND
b. COUNTY CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle John Last Collison
4. DATE OF DEATH Month March Day 10 Year 19 61

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH MAR 21, 1877
9. AGE (In years last birthday) 83 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM
10b. KIND OF BUSINESS OR INDUSTRY OWNER
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JAMES COLLISON
14. MOTHER'S MAIDEN NAME SARAH COHEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address Mrs Bertha Collison, Denton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hemiplegia
DUE TO (b) arteriosclerosis, Senility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 2/25 1961 to 3/10 1961, that (I) (we) last saw the deceased alive on 3/9 1961, and that death occurred at 1:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE P. E. Cox M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED
22c. PHYSICIAN'S NAME (Type) P. E. Cox M. D.
22d. ADDRESS Earle Avenue, Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Mar 12, 1961
23c. NAME OF CEMETERY OR CREMATORY Denton
23d. LOCATION (City, town, or county) (State) Denton Md.

24 FUNERAL DIRECTOR'S SIGNATURE J. Dwight Moore Son Denton Md.
ADDRESS
25a REC'D BY REGISTRAR DATE MAR 15 '61
25b REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3577 — 03570

1 PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgely
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: M.L. — Middle: ALEXANDER — Last: DAWSON
4. DATE OF DEATH: Month: MARCH — Day: 17 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-22-1893
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aircraft Mech. Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Wilson, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Dawson
14. MOTHER'S MAIDEN NAME: Lucy Erickson Simpson
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 209-32-2127
17. INFORMANT: Mrs. Erwin L. Hunter — Address: Ridgely Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Obstructive emphysema of L. lung — INTERVAL BETWEEN ONSET AND DEATH: 16 years
DUE TO (b): Chronic pulmonary tracheobronch.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cor pulmonale Bleeding peptic ulcer
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Nov 19 60, to March 17 19 61, that (I) (we) last saw the deceased alive on March 17 19 61, and that death occurred at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Kurt Lederer M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3/18
22c. PHYSICIAN'S NAME (Type): KURT L. LEDERER
22d. ADDRESS: QUEEN ANNE

23a. BLR AL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-20-61
23c. NAME OF CEMETERY OR CREMATORY: Greenwood
23d. LOCATION (City, town, or county) (State): Greensboro, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Boulden — ADDRESS: Greensboro, Md.
25a. REC'D BY REGISTRAR DATE: MAR 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03573

1. PLACE OF DEATH a. COUNTY 3578 Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 4days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Rosie Middle Brooks Last Glover
4. DATE OF DEATH Month March Day 31 Year 1961

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Feb. 23, 1886
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Cromwell
14. MOTHER'S MAIDEN NAME Millie Watkins

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-06-7819
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — 1 hour
DUE TO (b) Arteriosclerotic Cardiovascular Dis
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1961 to 31 March 1961, that (I) (~~we~~) last saw the deceased alive on 30 March 1961, and that death occurred at 4:40 AM, from the causes and on the date stated above

22a. SIGNATURE R. Lane Wroth M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 4-1-61
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth M.D.
22d. ADDRESS St. Michaels, Maryland 4/1/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF April 3, 1961
23c. NAME OF CEMETERY OR CREMATORY St. Michaels
23d. LOCATION (City, town, or county) (State) St. Michaels, Md.

24. FUNERAL DIRECTOR'S SIGNATURE James B. O'Neill — ADDRESS Easton, Md.
25a. RECEIVED BY REGISTRAR DATE APR 5 '61
25b. REGISTRAR'S SIGNATURE [illegible] S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3579 — 03574

1. PLACE OF DEATH — a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: QUEEN ANNES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CENTREVILLE
d. STREET ADDRESS: 122
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: Lindale — Last: Green
4. DATE OF DEATH: Month: 3 — Day: 5 — Year: 1961

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 11 APRIL 1898
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD SUDLERSVILLE
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: NATHAN BENTON
14. MOTHER'S MAIDEN NAME: KATHERINE WALLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: WILLIAM F GREEN CENTREVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS
DUE TO (b): CORONARY ATHEROSCLEROSIS — & TERMINAL 2 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CONGESTIVE HEART FAILURE, DIABETES MELLITUS
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. / p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 6 APRIL 1960 to 5 MARCH 1961, that (I) (~~we~~) last saw the deceased alive on 4 MARCH 1961, and that death occurred at 3:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: J. Kent Young M.D. — ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 5 MARCH 1961
22c. PHYSICIAN'S NAME (Type): J. KENT YOUNG
22d. ADDRESS: 105 CHESTERFIELD AVE. CENTREVILLE MD.

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial — 23b. DATE THEREOF: MAR 8 -1961 — 23c. NAME OF CEMETERY OR ~~CREMATORY~~: CHESTERFIELD — 23d. LOCATION (City, town, or county) (State): CENTREVILLE MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Jerrold V. Barton Jr. of Barton Bros. Centreville Md. — ADDRESS
25a. RECD BY REGISTRAR DATE: MAR 9 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3580

CERTIFICATE OF DEATH

03575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1 **PLACE OF DEATH** a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Easton
c. LENGTH OF STAY IN 1b: 35 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Easton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Thomas Middle: Last: Hughes

4. **DATE OF DEATH**: Month: Mch Day: 9 Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 7 1879

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Baltimore Md

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Hughes

14. MOTHER'S MAIDEN NAME: Frances Jordan Ballard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17 INFORMANT: Mrs Thomas Hughes Address: Easton Md Rd

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): arteriosclerotic Heart Disease — 10 yrs
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 1-5-61 to 3-9-61, that (I) (we) last saw the deceased alive on 3/8/61 and that death occurred at 6 P M, from the causes and on the date stated above.

22a SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mch 11 61

23c. NAME OF CEMETERY OR CREMATORY: Wye House Farm Easton

23d. LOCATION (City, Town, or County) (State): R.D. Easton Md

24 FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE: MAR 14 '61

25b REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 Film G265 3/21/61 jwk

Reg. Dist. No. 03576

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 34 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Balti. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1838 N. North Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Wesley — Last: Jackson

4. DATE OF DEATH: Month: March — Day: 6 — Year: 1961

5. SEX: M

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 6, 1904 (1902)

9. AGE (In years last birthday): 56 (58) yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Undertaker

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alfred Jackson

14. MOTHER'S MAIDEN NAME: Lizzie MC Cready

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wife — Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushing injury to chest c.extensive ~~to~~ — INTERVAL BETWEEN ONSET AND DEATH: 35hrs.

DUE TO (b): damage to lungs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): automobile accident

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of car in head-on collision on route 50 ; A. C.

20c. TIME OF INJURY Hour a.m. p.m. 8:10 — Month, Day, Year: 3/5 1961

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway

20f. (City or town) Stevensville (County) Q.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: C. R. Layton M.D.

EXAMINER'S NAME (Type): C. R. Layton

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/7/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/11/1961

22c. NAME OF CEMETERY OR CREMATORY: Christ Rock Cemetery

22d. LOCATION (City, town, or county) (State): Dorchester County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert Woolford Jr.

ADDRESS: Cambridge, Md.

24a. REC'D BY REGISTRAR DATE: MAR 13 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3582

CERTIFICATE OF DEATH

Reg. Dist. No. 13577

1 PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Trappe
c. LENGTH OF STAY IN 1b: 2½ yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ----

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Trappe
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ROBERT — Middle W. — Last LEWIS
4. DATE OF DEATH: Month March — Day 17, — Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Dec 10, 1893
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Clergyman
10b. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edward Lewis
14. MOTHER'S MAIDEN NAME: ? Foster
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO:
INFORMANT — Address: Mrs. Robert W. Lewis, Trappe, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Myocardial Infarction — 5 min
DUE TO (b): Congestive Heart Failure — 2 mon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Coronary Artery Heart Dis — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11-1, 19 60 to 17 March, 1961, that I last saw the deceased alive on 16 March, 19 61, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Lane Wroth M.D. — ADDRESS (Street, city or town, state): Box 487, St. Michaels, Md — DATE SIGNED: 3-18-61
PHYSICIAN'S NAME (Type): R. LANE WROTH, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar 20, 1961
22c. NAME OF CEMETERY OR CREMATORY: St. Mark's Cemetery
22d. LOCATION (City, town, or county) (State): Petersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. Hamilton Harrison, St Michaels Md
24a. REC'D BY REGISTRAR — DATE: MAR 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kemp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3583

CERTIFICATE OF DEATH

03578

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 19 da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X St. Michaels
d. STREET ADDRESS: 1 Chestnut
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jean — Middle: L. — Last: Miller

4. DATE OF DEATH: Month: Mar. — Day: 24 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 16 1886

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Hotel Clerk
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York City, N.Y

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Jean L Miller

14. MOTHER'S MAIDEN NAME: Elisa Robbins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Ethel Orr — Address: St. Michaels, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
DUE TO (b): Hypertensive Cardio Vascular Dis — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 March 1961 to 24 March 1961, that (I) (we) last saw the deceased alive on 3-24-1961, and that death occurred at 10:05 A M, from the causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 3/25/61

22c. PHYSICIAN'S NAME (Type): R. Lane Wroth M.D.

22d. ADDRESS: St. Michaels, Maryland 3/25/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-27-61

23c. NAME OF CEMETERY OR CREMATORY: Olivet Cemetery

23d. LOCATION (City, town, or county): St. Michaels (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: L. Hamilton Harrison — ADDRESS: St. Michaels Md.

25a. REC'D BY REGISTRAR DATE: MAR 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3584 (0357)

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 12 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgely
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Kennard — Middle: James — Last: Parks
4. DATE OF DEATH: Month: Mar. — Day: 4 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-12-1898
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wm. Bruner Parks Sr.
14 MOTHER'S MAIDEN NAME: Sadie Irland
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-18-4196
17 INFORMANT: Hilda Parks — Address: Ridgely, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial Failure -
DUE TO (b): (Advanced) Rheumatic Heart Disease 40 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): with Extensive Valvular Damage
INTERVAL BETWEEN ONSET AND DEATH: 12 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 1952 to 3/4 19 61, that (I) (we) last saw the deceased alive on 3/4 19 61, and that death occurred at 1:45 P M, from the causes and on the date stated above

22a SIGNATURE: Charles A Winnacott M.D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 3/6/61
22c PHYSICIAN'S NAME (Type): Charles Winnacott
22d ADDRESS: RIDGELY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-7-61
23c. NAME OF CEMETERY OR CREMATORY: Greensboro
23d. LOCATION (City, town, or county) (State): Greensboro, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Boulais — ADDRESS: Greensboro, Md.
25a. REC'D BY REGISTRAR DATE: MAR 9 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1E (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2585 03580

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 3 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Maryland b. COUNTY Caroline ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston – Rural
d. STREET ADDRESS Near Tanyard Ex-2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: EMMA Middle: Catherine Last: PERRY
4. DATE OF DEATH Month: MARCH Day: 23 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 10, 1889
9. AGE (In years last birthday) 71 yrs
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Kent County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Patrick
14. MOTHER'S MAIDEN NAME Emma Cole
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address: Charles F. Perry, Preston, Maryland, R.F.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia the cause undetermined — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
053.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic rheumatic heart disease Chronic fibrosis
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 20 Mar 1961 to 23 Mar 1961, that (I) (we) last saw the deceased alive on 23 Mar 1961, and that death occurred at 6:15 P.M. from the causes and on the date stated above

22a. SIGNATURE Thurston Harrison M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED 25 Mar 61
22c. PHYSICIAN'S NAME (Type) THURSTON HARRISON
22d. ADDRESS Easton Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF March 25, 1961
23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery
23d. LOCATION (City, town, or county) (State) Preston, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton & Son
ADDRESS Federalsburg, Maryland
25a. REC'D BY REGISTRAR DATE
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3586

CERTIFICATE OF DEATH

13581

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 230 da.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE MARYLAND b. COUNTY TALBOT
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS, Rural
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Pauline Middle Johnston Last Scofield

4. DATE OF DEATH Month March Day 8 Year 1961

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH AUGUST 23, 1893
9. AGE (In years last birthday) 67 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) CONN.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES CHARLES JOHNSTON
14. MOTHER'S MAIDEN NAME SARA FAULKNER FITCH

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT Address Kalsey B. Scofield St. Michaels, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH 8 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feby 1961 to March 8, 1961, that (I) (we) last saw the deceased alive on 3-8 1961, and that death occurred at 4:45 M, from the causes and on the date stated above.

22a SIGNATURE [signature] M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED 3/10/61
22c PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS M.D.
22a ADDRESS 210 E. Dover St. Easton Md

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 3-11-61
23c NAME OF CEMETERY OR CREMATORY Putnam Cemetery
23d LOCATION (City, town, or county) (State) Greenwich Conn.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [signature] Hamilton Harrison, St. Michaels Md
25a REC'D BY REGISTRAR DATE MAR 14 '61
25b REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3587 Reg. Dist. No. 03582

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Trappe
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Trappe
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First IDA Middle MAY Last SIMPSON

4. DATE OF DEATH: Month March Day 15, Year 1961

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 12, ~~1884~~ 1882
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Diffenderfer
14. MOTHER'S MAIDEN NAME: Sarah J. Dolby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
INFORMANT: Mr. Clifford Simpson Address: Trappe, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.K.A. - Coronary Heart Disease — 3 wks.
DUE TO (b) Generalized arteriosclerosis — 10 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 28, 1961, to 3-15, 1961, that I last saw the deceased alive on 3-14, 1961, and that death occurred at 9 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William L. Winters M.D. ADDRESS (Street, city or town, state): Easton Md DATE SIGNED: 3/17/61

PHYSICIAN'S NAME (Type): Dr. Wm. L. Winters Easton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 18, 1961
22c. NAME OF CEMETERY OR CREMATORY: Upper Bambury Cemetery
22d. LOCATION (City, town, or county) (State): near Trappe, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Newnam & Son
ADDRESS: Easton, Maryland
24a. RECD BY REGISTRAR DATE: MAR 20 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3588

CERTIFICATE OF DEATH

03583

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE Maryland b COUNTY Caroline
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg
d STREET ADDRESS R5 X A
e IS RESIDENCE ON A FARM? YES NO X

3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Todd

4. DATE OF DEATH Month March Day 8 Year 1961

5. SEX Male
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3/7/61
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours 2 Min. 22

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Mr Clifford R Todd
14 MOTHER'S MAIDEN NAME Bonnie Ee Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO None
17. INFORMANT Mr Clifford R Todd Address Fed. Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity 1 Week — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs 22 Min
DUE TO (b) Prematurity Birth
DUE TO (c) Cervical Incompetence (Mothers)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

74X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 3/7 1961, to 3/8 1961, that (I) (we) last saw the deceased alive on 3/7 1961, and that death occurred at 12:22 A.M., from the causes and on the date stated above.

22a SIGNATURE A. Tyler Baker M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED
22c PHYSICIAN'S NAME (Type) J. TYLER BAKER
22d ADDRESS Easton Avenue Easton Md

23a BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b DATE THEREOF 3/13/61
23c NAME OF CEMETERY OR CREMATORY Memorial Hospital
23d LOCATION (City, town, or county) (State) Easton Md

24 FUNERAL DIRECTOR'S SIGNATURE
ADDRESS
25a REC'D BY REGISTRAR DATE MAR 14 '61
25b REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

2080142 X V O

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3589

CERTIFICATE OF DEATH

Reg. Dist. No. 13584

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
d. STREET ADDRESS: Chew Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle EDWARD — Last WATTS

4. DATE OF DEATH: Month March — Day 18, — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb 6, 1885

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Seaman

10b. KIND OF BUSINESS OR INDUSTRY: St. of Md. Ferryboat

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Watts

14. MOTHER'S MAIDEN NAME: Kathlene Fairbank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

INFORMANT — Address: Marion C. Watts, St. Michaels, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 Min

DUE TO (b): Generalized Arteriosclerosis — 10 years

DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 55, to 18 March, 1961, that I last saw the deceased alive on 15 March, 1961 and that death occurred at 2:45 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: R. Lane Wroth M.D. — ADDRESS (Street, city or town, state): Box 489, St. Michaels, Md. — DATE SIGNED: 3-18-61

PHYSICIAN'S NAME (Type): R. LANE WROTH, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar 21, 1961

22c. NAME OF CEMETERY OR CREMATORY: Olivet Cemetery

22d. LOCATION (City, town, or county) (State): St. Michaels, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. Hampton Harrison, St. Michaels, Md

24a. REC'D BY REGISTRAR DATE: MAR 22 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3590

CERTIFICATE OF DEATH

Item 9 Film 0285 4/17/61 mh

0356

1 PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton — c. LENGTH OF STAY IN 1b: 6 da.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Henry — Last: Webb

4. DATE OF DEATH: Month: March — Day: 5 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 1, 1887

9. AGE (In years last birthday): 73Y4 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paper Hanger

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Webb

14. MOTHER'S MAIDEN NAME: Martha E. Sheppard

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 220-32-0188

17 INFORMANT: Nicie E Webb — Address: 318 East Ave. Easton, Md.

I

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hydronephrosis & hydroureter

DUE TO (c): Carcinoma of bladder

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on March 5, 19____, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

22a SIGNATURE: E. C. H. Schmidt M D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: 6 March 61

22c PHYSICIAN'S NAME (Type): E. C. H. Schmidt

22d. ADDRESS: Easton, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 3-15-61

23c NAME OF CEMETERY OR CREMATORY: Richards Cem.

23d LOCATION (City, town, or county): Easton (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James B. Dashiell — ADDRESS: Easton, Md.

25a REC'D BY REGISTRAR DATE: MAR 14 '61

25b REGISTRAR'S SIGNATURE: Clinton L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3591

CERTIFICATE OF DEATH

Item 9 Film G204 4/12/61 iwk

03586

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 20 hrs 15 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chester
d. STREET ADDRESS: 17X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Holland Middle Last White
4. DATE OF DEATH: Month March Day 31, Year 1961
5. SEX: male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 4-25-1894
9. AGE (In years last birthday): 66
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: oyster
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edward White
14. MOTHER'S MAIDEN NAME: Margaret Taylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 218-10-0399
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebellar Hemorrhage
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible], to [illegible] 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that death occurred at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE: E.C.H. Schmidt M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 31 March 1961
22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt
22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-4-61
23c. NAME OF CEMETERY OR CREMATORY: Chester Cem
23d. LOCATION (City, town, or county) (State): Chester Md.

24. FUNERAL DIRECTOR'S SIGNATURE: James B Parkhill Easton Md
ADDRESS

25a. REC'D BY, REGISTRAR DATE APR 6 '61
25b. REGISTRAR'S SIGNATURE: Anna L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3592 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03587

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 8 hr. 5 min
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp. Tal

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Henderson
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Zebrosky

4. DATE OF DEATH: Month: MAR — Day: 27 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-10-1888

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laboror

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: No Record

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-32-7718

17. INFORMANT — Address: Caroline Co. Welfare Board Denton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis Generalized — INTERVAL BETWEEN ONSET AND DEATH: 4 years

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Dawson O. George M.D.

EXAMINER'S NAME (Type): Dawson O. George

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 3-27-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-29-61

22c. NAME OF CEMETERY OR CREMATORY: Greensboro

22d. LOCATION (City, town, or country) (State): Greensboro, Maryland

23. FUNERAL DIRECTOR — ADDRESS: J. E. Boulais Greensboro, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 29 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis